GroupHealth

Benefit claim form

IMPORTANT—Please read the following before completing this form.

- Please submit one claim form per patient. All questions must be answered for prompt processing.
- Attach itemized bills from your medical care or service provider. The bill should include the patient's name, diagnosis, date of service, type of service, and charge.
- Keep a copy of your bills and this completed form for your records.
- Please **print** in ink.

Employee data

Member ID number ________________________________

Employee name ________________________________
Last First Middle

Home address ________________________________
Street City State ZIP

☐ Check box if address is new

Name of your employer ________________________________

Patient data

Patient name ________________________________ Member ID number ____________
Last First Middle

Date of birth ____________ Age ________ Handicapped dependent? ☐ Yes ☐ No

If this patient is a dependent child 19 or older, is child enrolled as a full-time student? ☐ Yes ☐ No

If yes, name of school ________________________ City ________________

If accident or injury, complete the following information:

Were these charges incurred as a result of an on-the-job illness or injury? ☐ Yes ☐ No Other accident? ☐ Yes ☐ No

Emergency? ☐ Yes ☐ No

If yes to any of the above, when did the patient first notice condition or symptom of illness? Month/date/year ____________

Place/time ________________ Description of what happened ________________

Other insurance data

Please read instructions on back of this page.

Is this patient employed? ☐ Yes ☐ No Is this patient covered by another employer health insurance plan? ☐ Yes ☐ No

If yes, list name and address of other insurance company List family members covered

________________________ Group number ____________ ____________

________________________ Phone ____________ ____________

Policy holder ________________ ID number ____________ ____________

Name of policy holder's employer ________________ Phone ____________ ____________

Is this patient covered by Medicare? ☐ Yes ☐ No If yes, please check one of the following: ☐ Part A ☐ Part B ☐ Both

Please make payment directly to: ☐ Health care provider ☐ Self

____
Signature of employee Date

I certify this information is correct and authorize the release of any medical information required for the administration of this claim.

____
Signature of patient (or parent if patient is a minor) Date

Instructions for coordination of benefits

If the patient has primary coverage with another plan, please submit the claim to that plan first for payment. After receiving the other insurance payment, send a copy of the original claim to Group Health Options, Inc. along with their Explanation of Benefits.

If you have any questions regarding coordination of benefits or other information regarding your covered services under Group Health Options, please call 1-888-901-4636.

Send completed form to:

Group Health Options, Inc.
Claims Processing
P.O. Box 34585
Seattle, WA 98124-1585

Tear along perforation and submit applicable form.

Prescription drug claim form

Member ID number ____________ **Subscriber name** ______________________________
(Please print) Last First Middle

Address ______________________ City ____________ State ___ ZIP ______

Daytime phone (including area code) ______________ Evening phone (including area code) ______________

Prescriptions were dispensed to:

Patient name ______________________________
Last First Middle

Patient birth date ________

Diagnosis or purpose of medication ______________________________

Is this medication for an on-the-job injury? ☐ Yes ☐ No

Is this medication covered under any other group insurance plan? ☐ Yes ☐ No

If yes, provide the name of the insurance company and other employer. ______________________________

(Note: Use a separate claim form for each covered member of the family.)

I certify that the information on this claim form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary for the administration of this claim.

Signature ______________________________
Patient (or parent if patient is a minor)

Please attach the duplicate pharmacy-generated receipt to this form.
If that is unavailable, please have the pharmacy or dispensing facility complete the section below.

Pharmacy or dispensing facility needs to complete the remaining portion and return this to the member. Shaded areas are optional; please complete those areas if information is available.

Rx number	Date filled	Check one:	Quantity	Directions	Days supply	Rx price w/tax
1)		☐ New ☐ Refill				
Medication name, form, and strength			DAW	M.D. DEA number	NDC number (11 digits)	
2)		☐ New ☐ Refill				
Medication name, form, and strength			DAW	M.D. DEA number	NDC number (11 digits)	
3)		☐ New ☐ Refill				
Medication name, form, and strength			DAW	M.D. DEA number	NDC number (11 digits)	
4)		☐ New ☐ Refill				
Medication name, form, and strength			DAW	M.D. DEA number	NDC number (11 digits)	

Pharmacy name ______________________ Pharmacy NABP (required) ____________

Address ______________ City ________ State ___ ZIP _____ Phone ________

Pharmacist's signature ______________________________

(Note: Pharmacist's signature only required when bottom of claim form is completed by pharmacy or dispensing facility.)

If you need assistance with this form, please contact the MedImpact Customer Service Department: 1-800-788-2949.
If you have prescription coverage questions, please contact your health plan Customer Service Department: 1-888-901-4636.

Submit claims to:

Group Health Options, Inc., Claims Processing, P.O. Box 34585, Seattle, WA 98124-1585

Tear along perforation and submit applicable form.